INCARCERATION AND BEYOND

Family Planning

Handout: Unwanted Pregnancy - Why?

By Pamela Lee Lowry

During its first three years of operation, the Pregnancy Counseling Service (PCS) of Boston saw nearly 20,000 women faced with an unwanted pregnancy. It has been impossible to witness such a steady stream of unwanted pregnancies without feeling a sense of dismay that so much effort must be devoted to a problem which should be easily prevented.

While PCS has its share of clients with very limited education or extremely low levels of intelligence, most couples seeking help have normal IQs, reasonable amounts of education, and adequate incomes. Why do such people conceive unwanted pregnancies? How can they be reached before they do, and motivated to seek and use contraception?

It is important, in seeking an answer, to go far beyond the oversimplified and questionable interpretation of unwanted pregnancy as a manifestation of some deep-seated pathology. This theory, extended to its logical conclusion, suggests that those who fail to wear seat belts have a hidden psychological need to be injured in a car accident, and that those who smoke subconsciously wish to get cancer. Clearly there are some people whose pregnancies are symptomatic of emotional illness or instability, but our experience indicates that they are definitely in the minority.

It is also important, in seeking answers, to avoid an approach which looks only to the female for the explanation, and neglects to ask what factors motivate a male to participate in unprotected intercourse.

To attack the problem effectively, we should consider all the factors which influence a person to participate in sex without taking adequate precautions against pregnancy. These range from human error, fear, and ignorance to conflicting priorities, social pressure and unconscious motivation. Certainly, we cannot overlook the fact that there is a small failure rate inherent in even the most effective contraceptive methods (pills, lUDs, diaphragms, condoms, foams). Some unwanted pregnancies are unavoidable, even when a couple has followed directions carefully and used an effective method consistently. For this small group, the only solution is improved contraceptive devices and continued research into new methods of birth control.

Unwanted Pregnancy - Why? (Continued)

Human Error

Unfortunately, the failure rate of effective methods is significantly increased because many couples use them without completely understanding the procedures involved. These couples believe they are using the method correctly, but due to a misunderstanding of the directions, or an inadequate explanation by the physician, they do not fulfill the requirements for highest protection. Examples of this are plentiful:

PlLLS

Physicians sometimes fail to emphasize the importance of taking pills at approximately the same time every day. With sequential pills and some of the lowest dose combination pills, the margin for error is slim. Further, women with a history of very short menstrual cycles should be advised to use another contraceptive in conjunction with pills for the first week of the first cycle. Doctors often neglect to mention this.

IUDs

Although heavy cramping usually accompanies the expulsion of an IUD, some women have not been advised of this warning signal, and may experience such cramping without realizing its possible significance. Many doctors do not place sufficient emphasis on the importance of the patient checking the string which hangs from the IUD into the vagina. By checking regularly, and particularly at a time when severe cramping takes place, women can usually tell whether their IUD is still in place.

DIAPHRAGM

Use of a diaphragm without spermicidal jelly or cream substantially reduces its effectiveness. Some doctors neglect to stress this point, and occasionally women will use a diaphragm without jelly or cream; not realizing the danger. Doctors often forget to explain that more jelly or cream must be inserted (by means of a plastic applicator) prior to each additional act of intercourse. Further, they may fail to caution that the diaphragm must remain undisturbed for 6-8 hours following intercourse to ensure that all sperm have been immobilized. Women are often not aware of the need to have their diaphragm checked periodically. Often it must be refitted following childbirth or weight changes, and 2-3 months after first intercourse.

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FOAM

The couple who fail to read the small print on the package of contraceptive foam often do not realize the importance of l) shaking the bottle well before filling the applicator; 2) inserting the foam no more than 30 minutes prior to intercourse; 3) refraining from douching for 6-8 hours following intercourse; 4) adding more foam prior to each additional act of intercourse.

CONDOM

Even with the supposedly simple condom, there can be problems. Sperm may be emitted in the lubricating fluid secreted before ejaculation. Not realizing this, many men do not apply the condom immediately following erection. Failure to remove the penis from the vagina before its return to a flaccid or non-erect state may result in leakage at the opening of the vagina. If there is sufficient lubrication, sperm deposited at the opening can cause pregnancy. A similar event could occur if the man does not hold onto the condom tightly as he withdraws.

VASECTOMY

Some men undergoing vasectomy do not realize that it does not immediately eliminate sperm from the reproductive tract. Others are mislead into thinking that after a set number of weeks or ejaculations, they can stop relying on other birth control methods. In fact, the only way to be sure the operation has been successful is to obtain a negative sperm count from the physician. Only then should other methods be abandoned.

There is, in general, a communication problem which plagues instruction about methods. Time and again, persons dispensing contraceptives fail to explain the most basic facts or use language which adequately conveys the information needed for effective usage.

While the majority of family planning patients understand that references to jelly or cream refer to a special spermicidal substance, there will always be women who assume the instructor is talking about a milk product or Welch's grape jam. The term sterilization means a surgical procedure to most, but to a patient with limited horizons, it may conjure up a frightening picture of a big pot of boiling water into which you are planning to dunk the anesthetized victim.

In one case which recently came to our attention, an unhappily pregnant patient returned to the clinic, completely bewildered as to why her diaphragm had failed. After reviewing the instructions with her, and confirming her proper usage, the doctor asked to see her diaphragm in order to check whether the size might have been wrong. She produced the device. It had a hole nearly the size of a dime punched through one side of it. "How on earth did that happen?" demanded the horrified physician. "Oh," she replied, "that's how I hang it on the hook by the bed, so it'll be handy like you said it should." Since the instruction she had been given omitted any explanation of how the device actually worked, she had no idea that a hole in the diaphragm constituted a problem.

Even the most conscientious family planning counselor may inadvertently use language which leads to disaster. A few years ago, a patient came in, fearing pregnancy and seeking an abortion. While the pregnancy test was being processed, a nurse talked with her about her contraception history. The woman had recently been fitted with a diaphragm, and told she should put it in every night before going to bed, and not to remove it till morning, so she would always be protected. This the woman did—correctly and faithfully. Unfortunately, her husband worked the night shift and they had intercourse during the day, after she had taken out the device. "Going to bed," for her, was not the same as having intercourse.

If we bridge the communication gap, "human error" in contraceptive usage can be reduced particularly if we are willing to recognize that responsibility for such error frequently lies with the deliverers of family planning care, as well as with its consumers.

Use of Ineffective Contraception

Human error and contraceptive failure (of an effective method) account for only 15% of the couples who come to PCS; 85% failed to use effective birth control at the time of contraception. The majority in this latter group were relying on methods whose effectiveness is low or nonexistent: withdrawal, feminine hygiene products, douching or rhythm.

IGNORANCE. . . A major factor in the use of such methods is ignorance of their high failure rate. Couples who believe withdrawal is effective are unaware that sperm are often released prior to ejaculation. Couples relying on post-coital douching have no idea that sperm can penetrate the uterus in a matter of seconds. Women using feminine hygiene products are misled by advertising that the product will "solve intimate marriage problems." Couples believe the woman cannot get pregnant during a menstrual period, or while breast feeding, or immediately following childbirth, or after coming off pills. Couples using rhythm—whether pure or modified—have no appreciation of the vagaries of the menstrual cycle. (Modified rhythm refers to couples who use effective contraception during what they assume to be the fertile period and use nothing during what they assume to be the safe period. Too frequently, their calculations are wrong).

FEAR AND EMBARRASSMENT...Even if couples are aware of the limitations of their current method and know that more reliable means exist, they may fail to seek help because they fear judgmental attitudes, or because they simply do not know how to go about it.

A co-worker conveyed to me the story which her boyfriend related about his first experience in purchasing condoms. Although it happened many years ago, it seems an ageless tale. He carefully avoided his home town drugstore, because the pharmacist lived two doors from his house. Manufacturing an excuse to get the car, he traveled to an area where he was not known. Having selected an appropriate spot, he parked the car and entered a corner pharmacy. Once inside, he started for the counter, realized that the attendant was female, and made a quick retreat into the magazine racks to reevaluate his position. After loitering there for what seemed an eternity, he spotted the male attendant beginning to circulate, and hastily headed toward him, magazine in hand. "Will that be all? "The attendant was ringing up the magazine. "Uh, would you add a box of Trojans, please?" He tried to look nonchalant. "Large or small?" responded the clerk. His face fell. Confused, he looked downward, made a quick assessment, and stammered, "Uh, m-m-medium" At this the clerk guffawed and through his chuckles, in a voice which carried throughout the entire store, said, "No, sonny, condoms all come in the same size. I was talking about the box—you want three per or the twelve pack?" The mortified boy fled the drugstore—without the magazine—and without the condoms.

Needless to say, fear of a similar experience inhibits untold numbers of young men from purchasing condoms.

The woman faces parallel problems. She has read about pills, but is not sure of their availability. She thinks there may be age and/or marital restrictions and does not know where to turn for accurate information. She is reluctant to approach her regular family doctor for fear he will inform her parents. Students almost uniformly suspect that any college health service will send their records home. The woman who picks a doctors name out of the phone book runs a fair chance of being met with a lecture on morality by either the secretary or the physician. Fear of possible judgmental and punitive attitudes is enough to make many women give up early in their search—or never even try.

In a slightly different vein, certain effective contraceptives such as diaphragms or foams are rejected because they require genital handling. A surprising number of women have been deeply affected by traditional female taboos and carry into their adult lives a repugnance for any method which requires them to touch the genital area. This embarrassment can also be a strong factor in a woman's failure to seek prescription contraceptive methods like the pill or the IUD, since both require a pelvic exam. The prospect of an internal exam is awkward for many women, and often leads to procrastination over scheduling a doctor's appointment.

Many couples are reluctant to use the most effective methods because of the often over-stated dangers attributed to them. Scare stories about pills and lUDs have kept many couples from trying these methods. While clearly there are women who should not use pills or lUDs, most couples neglect, in weighing the pros and cons, to consider the major side effect of lesser methods: failure.

COST. . . Socio-economic concerns are another major deterrent to effective contraceptive practice. Many areas of the country have no clinic services for birth control; those that do often have restrictions which sharply limit eligibility. Some centers offer free services for welfare recipients within a specific geographic limit, but will not give care to the non welfare but medically indigent person, to street people or to poor students. The few services which are open to this population usually have waiting lists as long as two or three months. Withdrawal and rhythm may not work very well, but they are free and immediately available. Come now, pay later.

Conflicting Priorities

Yet even in instances where money is no problem, where a couple has knowledge of and access to effective contraception, with confidentiality and minimum hassle guaranteed, pregnancy seems to occur with depressing predictability.

Unwanted Pregnancy - Why? (Continued)

Among the very high risk groups are women who are just entering into a physical relationship. Having been brought up to believe that "nice girls don't", these women are often unable to confront and deal realistically with sexual intercourse and its reproductive component. Planning to use a contraceptive means planning to have intercourse—and nice girls don't. Even more central to the issue is the teaching that nice boys don't marry girls who do. There is frequently a very high level of anxiety that the boy will lose respect for a girl who willingly, consciously agrees to have intercourse. Premeditation is a cold and ugly word. It is contrary to every major role model the girl has been shown during childhood and adolescence. Society condones and romanticizes seduction— being swept away by love, overwhelmed by passion—but it decries planning.- The unspoken code does not even permit her to ask her boyfriend to take care of contraception, since that would be equally an admission that she is a consenting participant. The mere act of verbalizing the need for birth control demonstrates her acknowledgment, at a conscious level, of their sexual relationship; such acknowledgment forces upon her the burden of responsibility for her actions—and since she cannot be both an instigator of sexual activity and a nice girl, she opts for the best of both worlds by avoiding responsibility for her actions.

Her conflict, in turn, makes it very difficult for the male to take initiative in terms of contraception. In a very succinct, albeit nonverbal fashion, she communicates to her partner that she does not wish to be confronted with her actions, and that if she is forced into a position of seeming to be cognizant, she has little choice but to refuse to participate. For the male to stop at a crucial moment and fumble with a condom is to invite a sudden reversal of the natural course of events. The girl conveys that she must be swept away—no planning—no premeditation and in order for intercourse to occur, the boy must act in a manner consistent with this approach. He cannot bring her back to reality by pausing for practical, contraceptive activity.

Neither partner wants a pregnancy. Both partners want to have sex. Yet because of the conflicts inherent in their social circumstance, an order of priorities emerges which militates against effective contraceptive practice for the first several occasions of intercourse.

The high risk of the above setting is compounded by the all-pervasive human belief that "it won't happen to me." Automobile accidents and pregnancies only happen to other people. The relationship of cancer to cigarettes and pregnancy to sex are facets of reality which are temporarily ignored to satisfy a higher, more urgent and tangible priority. This involves a denial mechanism with obvious psychological implications, but it is so ubiquitous in the human personality that it cannot be labeled as pathological or abnormal. Couples often pay genuine respect to statistical risks of pregnancy over a long term basis, but manage to ignore the fact that all it takes is once. PCS once counseled an MIT student and his pregnant girlfriend; as a mathematics major, he had calculated that statistically it takes an average of three months to conceive, and they therefore used no contraception during the first two and a half months of their relationship.

Spontaneity

Some couples dislike contraceptives because they feel that consistent and methodical usage detract from the spontaneity of sex. This occurs particularly with couples who have tried methods which are intercourse related (e.g. Diaphragm, Foam or Condom). Passion and the natural sequence of events contribute to these products being left in the bathroom cabinet. Even if the effort was made first time around, the motivation to add additional jelly or foam, or break out a new condom, is frequently lacking in the event of additional lovemaking. The hassle of preparation — the messiness of foams and diaphragms—the lessened sensation some men experience with condoms— all result in a heavy reliance by many couples on modified rhythm with a dash of luck.

There is another factor, too—less easily identified, but almost consistently present in the group that objects to contraception because it "detracts" from sex. It has to do with their perception of intercourse, a perception heavily influenced by mass media.

If asked to conjure up a picture of the classic movie love scene, most people would include the following basic ingredients: First, the perfect couple—he is strong, handsome, no pimples; she is attractive, has shiny hair, clean teeth, and absolutely smooth, newly shaved legs They meet in a setting which is a visual treat. If outdoors, they are near a waterfall or pounding ocean surf, or perhaps in a golden field, or in a woods where the sunlight filters gently through the leaves and makes patterns on the forest floor. There is a conspicuous absence of mosquitoes, ants, sand flies, and other biting, stinging, buzzing, slithering creatures. If indoors, there are candles burning, or a dancing fire, throwing flickering shadows against the wall, or simply subtle, subdued lighting which changes with every shift in camera angle. The audio setting is also impressive. Depending on the age of the lovers, there is either a haunting, bitter-sweet flute solo, a powerful build-up of violins, or a tense, insistent sitar whose tone and rhythm build to a fever pitch—or, back outside, the richness of bird calls and bubbling water strengthen and grow.

Against this background, the couple come together, either across real or imagined space, and in one graceful, fluid movement, virtually without a hitch, they float from vertical to horizontal as if they were a tree whose felling was caught in the slowest of slow-motion pictures. They don't even bounce when they hit bottom. This whole process is a truly remarkable feat, in and of itself. It is even more remarkable when you consider that nowhere between the vertical and the horizontal did the man stop, bend over, reach down, untie his shoe laces and take off his shoes. Yet the audience does not think this is at all strange, even though they know that short of fetishists and sadomasochists, people—particularly men—avoid making love with their shoes on. But if the real story were portrayed, complete with stubborn, knotted laces, the audience would suspect it had ventured into a Woody Allen movie by mistake, and whatever swooning and excitement had begun would quickly change into roaring laughter, laughter born of gut level identification.

What has all this to do with contraceptive use or non-use? Everything—because most people deal with contraception in the-same way as the issue of taking off your shoes. It is an act which somehow detracts from the ideal image of lovemaking. It is awkward and pedestrian. Inundated by the steady stream of mass media propaganda which carefully screens out the homely, mundane aspects of copulation, most people block out much of the reality (including the reproductive reality) of intercourse in favor of an erotic or romantic fantasy. When couples say that birth control detracts from sex, they are often expressing a discomfort with the bodily, functional aspects of intercourse. Motivated by a distaste for the biological reality, or perhaps by a frustration at not yet having successfully duplicated the silver screen model, they concentrate all their attention on the socially sanctioned, media endorsed romantic ecstasy which they perceive to be the norm.

Such couples have not reached a point in which they can blend the emotional with the physical, the fantasy with the real. Birth control should not detract from sex if the couple accepts the full scope of sexuality and maintains a healthy, positive attitude toward their bodies, their genitalia and their reproductive capacity. For those who cling to the media image, however, birth control cannot help but be an intrusion, since it constitutes an absolute invasion of the real world into a fantasy.

There are several variations on the above theme. For some couples, the greater the risk, the greater the fun. There is little thought that they might actually get caught, yet knowing they are cheating the system adds a great deal of spice and enhancement to sex. The immediate gratification and exhilaration resulting from taking chances has greater importance for the couple than what seems to them the mundane process of insuring against an "accident." Here again we are dealing with a question of maturity and balance, and it is a question not easily answered given our cultural schizophrenia about sexuality.

The avoidance of responsibility, the denial of a clear and present danger, and the problem of conflicting priorities all work, either independently or in concert, to promote staggering numbers of unwanted pregnancies. Often underlying this is a lack of faith in one's own ability to cope with the complexity of the world we live in, and the fear that one is somehow incapable of successfully plotting a realistic yet rewarding course of action.

In various situations cited thus far, there is clearly individual culpability, but even more important, there is societal culpability. We cannot begin to expect each individual to deal with sexuality in a mature, healthy and responsible fashion if society collectively insists on maintaining its distorted and contradictory posture concerning sex. The norm is confusion, and we should not be surprised that the normal are confused.

Subconscious Issues

In the examples used above, conflicts center around the use of birth control and its implications both in terms of sexual expectations and self-esteem. There is another group, long the focus of psychiatric literature, for whom pregnancy arises out of a different form of conflict, the conflict between pregnancy as a negative versus a positive event. This conflict operates within many diverse settings, but always with the basic rule that pregnancy at one level seems unwise, illogical, even disastrous, and at another, desirable or at least useful in achieving some significant goal. It should be noted that in most such cases, pregnancy is perceived as being quite different and remote from parenthood.

Take, as an example, a couple who have developed and maintained a relationship for some period of time (whether in or out of wedlock is not necessarily significant). For one of a dozen reasons, the nature and/or future of the relationship may come into question. There may be mismatched expectations, uneven commitment, lack of meaningful communication or whatever. Anxiety develops, and will continue to heighten so long as the couple avoids confronting and dealing with the source of the tension. Yet to confront is to run a risk. The confrontation may bring about a resolution which is contrary to the desires of the confronter.

Still, the relationship needs clarification. The uncertainty must be dealt with eventually. For many, this is managed by letting an outside force intervene, and if necessary, become the scapegoat in the event that the ending is not a happy one. A pregnancy for which they share the responsibility (or, as it may be, for which neither can be blamed), becomes the vehicle for dialogue. In a very real sense, the pregnancy was in part planned and in part wanted, even though both parties may have no wish to become parents, and so seek to obtain an abortion.

The use of pregnancy as a means of dealing with uncertainty is in no way limited to male-female relationship problems. Just as frequently perhaps even more frequently—it occurs when the issue is self image or a self-society relationship problem.

The student approaching graduation may be overwhelmed by the many decisions ahead. The conflict of new versus traditional ideas about female roles deeply affects many women at this time. On the one hand they feel a growing consciousness, a desire to achieve, to secure for themselves the freedom to be and create, each according to her ability and her choice. On the other hand, everyone facing the competitiveness of law schools, medical schools, business careers and the like is intimidated by the prospect, and women bear the additional burden of all the psychological blocks and frustrations inherent in a male-dominated society.

Logically, consciously, the woman may wish to proceed with her graduate studies and career plans; yet the struggle ahead seems frightening and at times she wishes she could escape from the inevitable pressures to come. Add to this the anxiety created by the upcoming separation from friends upon graduation, and the scene is set for a fling at escape and the seeming security of marriage via pregnancy. Once pregnancy actually occurs, however, she tends to reject it, because at a conscious level, she realizes that motherhood or even continuing to term and releasing the baby for adoption—could, at this time in her life, be disastrous. The fantasies about pregnancy are quickly dispelled by the realities.

Unwanted Pregnancy - Why? (Continued)

Adolescent girls may use pregnancy as a means of testing the extent of their parent's love for them—or at the other extreme, may see pregnancy as a means of proving their independence and maturity, and escaping from their parents and home situation.

Women who are conflicted about themselves and their role in society may seek pregnancy as a means of confirming their femininity. Similarly, men may seek to impregnate women to prove their virility.

Women whose sexual activity is in extreme conflict with their religious or moral upbringing may open themselves to pregnancy as a punishment for their "sin."

The examples are limitless. Case studies fill the pages of psychiatric and counseling journals. The one discernible pattern which seems to appear in so many of these case histories is an inability to deal on a logical level or in an open, conscious, and optimistic manner with normal human fears and insecurities, particularly in the area of relationships and self image. The result is too often a reliance on fate or some other indirect force to determine the course of events, and even one's life.

In many of the cases we see, pregnancy is a tool—a means to an end. Yet childbirth and parenthood are rarely considered part of that end. Until a person understands the psycho dynamics involved, he or she is unlikely to make much progress in resolving the underlying problems which motivated the pregnancy to begin with. Just distinguishing between feelings about becoming pregnant versus remaining pregnant can be a tremendous first step.

Unhappily, it is far simpler to categorize the problems than to propose effective solutions. Where the cause of unwanted pregnancy is inaccurate information or limited availability, comprehensive birth control and sex education programs are the logical answer. In most instances, however, pregnancy results from the inability of individuals to relate responsibility to themselves, their world, and the people in it. Society thus far hasn't helped a great deal. What is needed, it seems, is a social revolution—a genuine "People's Liberation' which would include:

- a breaking away from artificial roles, unwarranted social pressures, Victorian conventions and double standards, and unreal expectations;

- a re-evaluation and re-orientation of traditional concepts of "romance" and male-female relationships;

Unwanted Pregnancy - Why? (Continued)

— a realization that one's worth as a person is a function of one's own head, not someone else's— that feelings of certainty, inadequacy and fear are part of the human condition and need not be hidden away from the rest of the world;

— a recognition that reality is more rewarding than fantasy—that caring for people as they are is a vastly richer experience than caring for a body on which you have imposed a superstructure of expectations;

— an attempt at discovering, promoting and just plain enjoying all that is positive and valuable in ourselves and others;

— an attempt at giving without putting price tags on love or friendship—without demanding "x" amount of return for "x" amount of feeling given;

— an effort to communicate verbally, physically, in whatever way and on whatever level works, a constant and honest exchange of thoughts, feelings, concerns hopes;

— an attempt at living in the real world and sharing that reality with people you care about.

Some of this may sound abstract, yet what is happening with people's heads is substantially more relevant to this issue than what is happening with their genitals. If we as a society could recognize and accept this fact, and deal with our feelings and our needs in an honest and open manner, there would be—among other benefits—a substantial decrease in the number of unwanted pregnancies.

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Family Planning

Teacher Notes

Teacher begins session by stating the situation: The girl is pregnant, the student had sex with her, she attends the same school, all their friends know about the pregnancy, and their parents have just found out.

Ask the questions: What are the students going to do? What are their choices? Ask students to describe what the options are.

Expect to hear some of the following offered as choices:

1. Abortion. Ask them if they can make the choice about abortion, or if that is up to the girl. What if she wants an abortion and they don't?

2. Helping her raise the baby (in some communities, marriage may be considered an option for teens). Ask what do they do if the girl doesn't want to have them involved with the baby. If she does, ask how they can get money to support a child.

3. Adoption. Ask them what happens if the girl wants to keep the baby?

4. It's her problem; I don't have to be involved. Remind them about paternity testing, which can require them to be at least financially involved in supporting the child. Also bring up the issue of a child growing up without a father. How does that child feel?

After the participants discuss these options, ask them how the situation makes them feel about:

a. Having unprotected sex

b. Using condoms in the future

c. Themselves as adults

The facilitator closes the discussion by pointing out that, at the bottom line, they have no choices at all (with the possible exception of deciding to parent if the girl wants to give the baby up for adoption)

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Family Planning (Continued)

The nurse may want to begin the discussion of condom use by a putting a condom onto a rubber penis. This may include a discussion of foreskins and circumcision. This visual demonstration may help the nurse cover practical points such as:

- orienting the condom right-side out
- making the condom a part of foreplay
- using a water-based lubricant (one that will not break down latex)
- using lubricant on the woman to prevent condom from breaking due to friction

The nurse will discuss what a condom protects against:

- pregnancy (particularly when combined with spermicide)
- AIDS and other STDs

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Family Planning

How Much Does a Baby Cost?

How much does a teen with a baby spend per month? Fill in the blanks to find out:

_____ Rent (l-bedroom apartment)
_____ Food (groceries, baby food, eating out)
_____ Utilities (heat, hot water, electricity)
_____ Phone
_____ Clothes, including baby clothes
_____ Diapers (disposable, or diaper service)
_____ Child care (day care, baby sitter)
_____ Transportation (public trans. or a car)
_____ Medical care (including insurance)
_____ Entertainment (cable TV, etc.)

_____ TOTAL MONTHLY BUDGET

How much would you need to make per hour to meet these expenses? _____

You would need to have take-home pay, after all deductions, of enough money to equal the total monthly budget figure above. Write that figure : ____

Net Monthly Pay-divide it by .80 to equal Gross Monthly Pay; now, multiply by 12 months to get Gross Annual Salary = ___

Divide this by 2080 hours in the work year to equal your Hourly Wage _____